

**Urology Center of Columbus, LLC**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Last Name First Name Middle Name

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Phone-Home:** ( ) \_\_\_\_\_ - \_\_\_\_\_ **Phone-Work:** ( ) \_\_\_\_\_ - \_\_\_\_\_ **Ext:** \_\_\_\_\_ **Phone-Cell:** ( ) \_\_\_\_\_ - \_\_\_\_\_

**Sex:** \_\_\_\_\_ Female \_\_\_\_\_ Male **Marital Status:** Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Legally Separated \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Age:** \_\_\_\_\_ **Race:** \_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_ @ \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ **Primary Care Physician:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Spouse's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Phone-Work:** ( ) \_\_\_\_\_ - \_\_\_\_\_

**(Name of nearest relative not living with you) Emergency Contact:** \_\_\_\_\_  
Last Name First Name Middle Name

**Phone-Home:** ( ) \_\_\_\_\_ - \_\_\_\_\_ **Phone-Work:** ( ) \_\_\_\_\_ - \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Medical Alerts:** \_\_\_\_\_

**Allergic To:** \_\_\_\_\_

**COMPLETE IF PATIENT IS MINOR AND/OR STUDENT**

**Fathers Name:** \_\_\_\_\_ **Mothers Name:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Phone-Work:** ( ) \_\_\_\_\_ - \_\_\_\_\_ **Phone-Work:** ( ) \_\_\_\_\_ - \_\_\_\_\_

**INSURANCE PLAN INFORMATION**

**Primary Insurance Plan:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_ **Referral Required:** \_\_\_\_\_ yes \_\_\_\_\_ no

**Primary Insured's Name:** \_\_\_\_\_ **Primary Insured's Date of Birth:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Secondary Insurance Plan:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_ **Referral Required:** \_\_\_\_\_ yes \_\_\_\_\_ no

**Primary Insured's Name:** \_\_\_\_\_ **Primary Insured's Date of Birth:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Tertiary Insurance Plan:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_ **Referral Required:** \_\_\_\_\_ yes \_\_\_\_\_ no

**Primary Insured's Name:** \_\_\_\_\_ **Primary Insured's Date of Birth:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

IF YOUR INSURANCE COMPANY REQUIRES THAT YOU HAVE A REFERRAL FORM, IT IS YOUR RESPONSIBILITY, AS THE PATIENT, TO GET YOUR REFERRAL FORM FROM YOUR PRIMARY CARE PHYSICIAN. I UNDERSTAND THAT I AM RESPONSIBLE FOR THE CHARGES FOR MEDICAL SERVICES RENDERED.

I HAVE BEEN PRESENTED WITH A COPY OF THE NOTICE OF PRIVACY PRACTICES, DETAILING HOW MY HEALTH INFORMATION MAY BE USED AND DISCLOSED AS PERMITTED UNDER FEDERAL AND STATE LAW, AND OUTLINING MY RIGHTS REGARDING MY HEALTH INFORMATION.

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE ABOVE PROVIDER FOR SERVICES RENDERED. I AUTHORIZE RELEASE TO THE INDICATED INSURANCE CARRIER ANY MEDICAL INFORMATION ABOUT ME NEEDED TO DETERMINE THESE PAYMENTS FOR RELATED SERVICES.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_



**Are you experiencing or have you ever experienced any of the following....( Please check all that apply)**

- Frequent Headache
- Fever/Chills
- Weight Loss \_\_\_\_ lbs
- Nausea/Vomiting
- Abdominal Pain
- Constipation
- Diarrhea
- Back Pain
- Neck Pain
- Pelvic Pain
- Skin Rashes
- Skin Lesions
- Cataract
- Glaucoma
- Blurred/Double Vision
- Blood in Urine
- Pus in Urine
- Frequent Urination
- Uncontrolled Loss of Urine
- Excessive Thirst
- Feeling of Being Tired
- "Out of Sorts" feeling
- Drug Allergies
- Seasonal Allergies
- Ear Infection
- Difficult Hearing
- Bleeding Gums
- Sore Throat
- Depression
- Anxiety
- Sleep Disorder
- Overly Stressed
- Chest pain
- High Blood Pressure
- Dizzy Spells/Vertigo
- Numbness/Tingling
- Shortness of Breath
- Trouble Breathing
- Swollen Glands
- Easy Bleeding or Bruising
- Swollen Lymph Nodes
- I have not experienced any of the above.

**I/My Family has a history of ...( Please check all that apply)**

	Me	Family	Explain:
Breast Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes I/II	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Female Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol/Triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/Aids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headache	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hormone Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	_____
OAB/Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach Ulcers/Reflux/GERD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sickle Cell Anemia /Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spine Injury/Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you have any allergies?  Yes  No  
 If yes, please list \_\_\_\_\_

Do you take any medication?  Yes  No  
 If yes, please list the medication and dosage:

<u>Medication</u>	<u>Dosage</u>	<u>Medication</u>	<u>Dosage</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you undergone a surgical procedure?  Yes  No  
 Please list surgeries/hospitalizations, dates, physician performing procedure and name of hospital.

<u>Surgery/Illness</u>	<u>Date</u>	<u>Surgery/Illness</u>	<u>Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is your Marital Status?  Single  Married  Divorced  Widow

What is your occupation? \_\_\_\_\_ Number of Children \_\_\_\_\_

Do you smoke?  Yes  No  
 If yes, # of packs per day?  Less than one  Two  One  Three or more  
 For how long? \_\_\_\_\_

Do you drink alcohol?  Yes  No  
 If yes, how much?  Social  Moderate  Light  Excessive  
 For how long? \_\_\_\_\_

Do you experience leakage of urine when you sneeze, laugh or cough?  Yes  No  
 Do you experience leakage of urine when you exercise?  Yes  No  
 Do you wear a pad for leakage of urine?  Yes( # per day \_\_\_\_ )  No  
 Do you experience leakage of urine if you do not get to the bathroom immediately?  Yes  No  
 Do you urinate small amounts?  Yes  No  
 Do you dribble urine throughout the day?  Yes  No  
 Do you experience a feeling of not completely emptying your bladder after urination?  Yes  No  
 Do you go to the bathroom frequently?  Yes  No  
 Do you have pain with urination?  Yes  No  
 Have you seen blood in your urine?  Yes  No  
 Have you gone through menopause?  Yes  No  
 Do you have menstrual periods?  Yes  No  
 If yes, are they regular?  Yes  No  
 Do you use birth control?  Yes  No  
 If yes, what method? \_\_\_\_\_  
 Is there a chance you may be pregnant?  Yes  No  
 If applicable, please list: # of pregnancies \_\_\_\_\_ # of births \_\_\_\_\_

When was your last menstrual period? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reviewed By \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_